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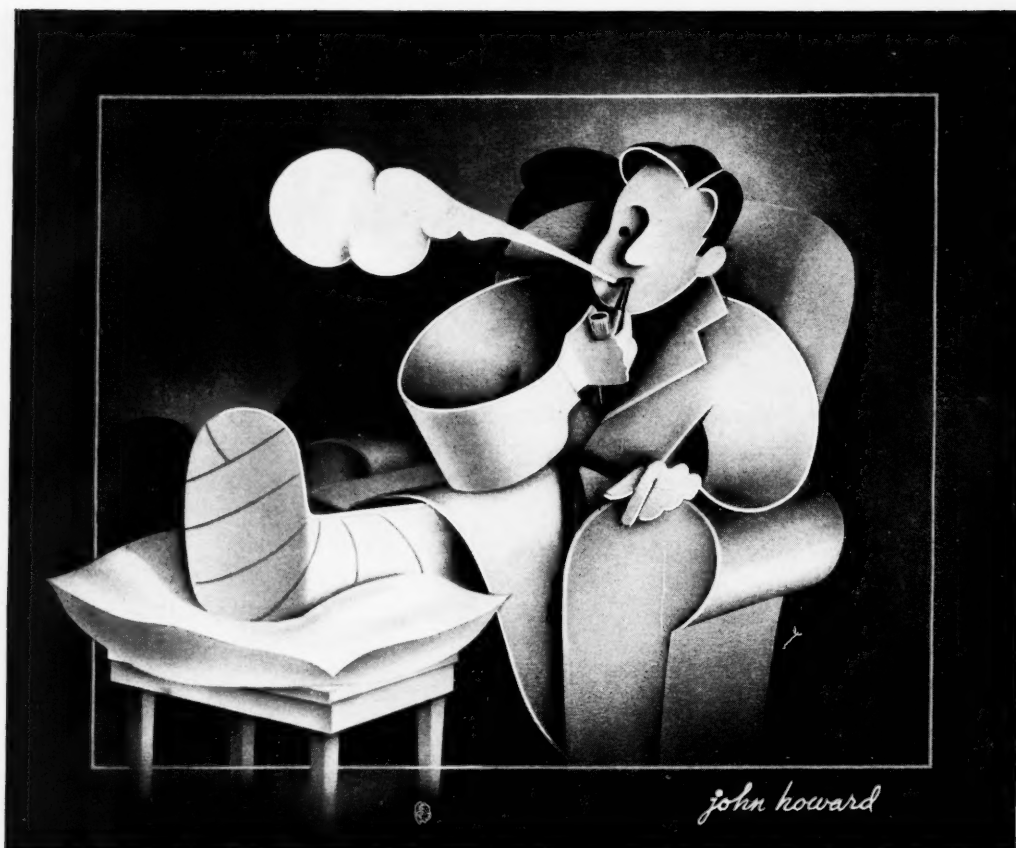
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VOLUME XXIII

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BACTERIAL ENDOCARDITIS AND SYPHILITIC HEART DISEASE

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The engrafting of a bacterial endocarditis upon an already diseased valve is, in most instances, a fact generally accepted. That the pre-existing valvular lesion should be syphilitic, however, has in general been considered a rarity. Most text-books mention it as one possibility, only to pass on to descriptions of the implanting of the infection upon old rheumatic lesions, or, less frequently, arteriosclerotic changes with calcification or congenitally malformed valves. This, even though syphilis is the second most common cause of valve defects and bacterial endocarditis quite often has a selective action for the aortic valve.

My interest in the association of bacterial endocarditis and syphilitic valvulitis was first aroused after having seen two cases within the last year, presented at the Clinical-Pathological Conferences at the Baltimore City Hospitals, and this led me to wonder if the combination might perhaps occur more frequently than has been thought. Investigation of the literature relative to these two conditions and their possible association proved of special interest because of the infrequency of case reports pertaining to the combination.

Lancisi, in 1707, recorded the first clinical and pathological observations in a case of vegetative endocarditis, but it was not until the latter part of the nineteenth century that it was recognized that valves upon which vegetations had developed were quite commonly the seat of some pre-existing damage. Since then numerous articles have appeared on the association of bacterial endocarditis and old rheumatic valvular lesions. Paget noted that congenitally malformed aortic valves, especially bicuspid, were commonly liable to the development of bacterial vegetations, and in more recent years the fact that the congenital valves had previously been affected by rheumatic deformities, making them more liable to implantation, had been emphasized.

Cardiovascular syphilis, with reference to aortitis and deformities of the aortic valves, was first adequately described by Francis H. Welch in 1875, but it was not until some years later that the general clinical and pathological concepts of this condition became widely known. Perhaps this relatively recent understanding of the changes taking place in the aorta and aortic valves following their invasion by the spirochete is one reason for the lack of reports noting its association with bacterial endocarditis.

Thayer, in his excellent monograph, "Studies on Bacterial (Infective) Endocarditis," published in 1926, reviewed 362 cases which had come to autopsy at the Johns Hopkins Hospital during a thirty-four and one-half year period. He comments on the surprising rarity of syphilitic aortitis or valvulitis appearing in any of these cases; admitting only the pathological evidence of syphilis in four, and doubtful of the part it played in these as a basis for the development of vegetations. He stresses the fact that in the more acute forms of bacterial endocarditis, previously perfectly normal valves have been involved, and notes that this does occur with regard to the aortic valves while the aorta just beyond may show a syphilitic change. Numerous other authors writing on the subject either speak of the rarity of the combination of lesions or question their association. Libman commented on several occasions upon this fact, notwithstanding the frequency of syphilitic valve defects; and Cotton on the common occurrence of a vegetative process on the normal aortic valve alone. Clawson, in 1924, reported 220 cases of bacterial endocarditis, in none of which was the condition found in combination with syphilis of the aorta or valves. Smith observed in acute endocarditis that normal valves are the ones involved in more than one-half of the cases seen, and thinks that this is only an incidental manifestation in the evolution of a septicemia.

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Read at Interne Alumni Clinic Day, The Memorial Hospital, Pawtucket, R. I., Wednesday, November 1, 1939.

Apparently, the first case report proving the relationship of pre-existing syphilitic aortic valvular disease and bacterial endocarditis is that of Kastner in the "German Archives of Clinical Medicine" in 1918. A white male of 54 years, with positive Wassermann, the clinical course of bacterial endocarditis, in section showed syphilis of the aorta and aortic valves with aortic bacterial vegetations. In 1922 LeRoy Briggs (American Journal of Medical Sciences) writes of a thirty-five-year-old white male known to have had syphilitic heart disease with aortitis and aortic insufficiency, and a positive Wassermann in 1917. He was seen three years later with a classical picture of subacute bacterial endocarditis, having a positive blood culture of streptococcus viridans. Autopsy showed a syphilitic aortitis and valvulitis with acute verrucose endocarditis involving the aortic cusps and extending to the anterior mitral leaflet. In comment, he speaks of the rareness of the association.

A case report by Landau and Held (Bulletin of the Hospital of Paris, 1925) of a "Positive Wassermann Test in Slow Malignant Endocarditis" and included in some compilations of positive cases, is, however, most questionable, as there is a history of rheumatic fever in childhood, vegetative lesions being present on the aortic and mitral valves, and no evidence for syphilis of the aorta or aortic valves is mentioned.

In 1926 two reports appear: Cade, in the French literature, and Pineles, in the German, each describe a case with clinical evidence of aortic insufficiency, positive Wassermann, and clinical bacterial endocarditis, which showed on anatomical study gross and microscopic evidence of syphilitic aortic valvulitis with superimposed large vegetations. Blood cultures of streptococcus viridans were obtained in each instance. Gallavardin and Gravier (Lyon Medicine), in 1927, discussed a most interesting case of bacterial endocarditis in a forty-four-year-old woman who had syphilis of the aorta with three aneurysms, around the mouths of which there were large vegetations extending downward to the aortic and mitral valves. They noted, however, that the aortic leaflets were delicate and the commissures intact, evidence against primary aortic valve disease. In 1928 Jacoslaw Sumbal reported a most questionable case, which should not be included in any confirmative group.

Schnabel and Leivy (Medical Clinics of North America, 1931) and Craven (American Journal of

Pathology, 1932) are apparently the next reporting authenticated cases in which there was demonstrable pathological evidence of syphilis of the aortic valves and aorta, aortic vegetations and positive blood cultures of streptococcus viridans. Craven in his case remarks on the absence of any evidence suggesting rheumatic valvular change.

In 1934 two other case reports appeared in French literature as confirming the association of the syphilitic cardiovascular change and infectious endocarditis, but which I feel are not proven. Francois and Jouve's case showed calcification of the aortic cusps and induration of the mitral, rather suggesting that an old rheumatic lesion was the basis for the subsequent infection. The patient of Brahic, Recordier and Sarrodin, known to have had aortic insufficiency and positive serology two years, showed the presence of aortic vegetations, but no mention is made of syphilis of the valves and attention is called to a sclerosing change of the mitral valve.

Raybaud, Jouve and Farnarier (Bulletin of the Hospital of Paris, 1935) presented the case of a fifty-year-old woman with aortic insufficiency and a subacute septicemia but with doubtful serology, who at section showed evidence of syphilitic aortitis and valvulitis with superimposed vegetations, and in 1936 Raybaud and Jouve reviewed eight previously reported cases collected from the literature, several of which have been included here but the remainder discarded as not showing conclusive evidence of syphilis of the valves.

McMillan and Wilmer (Journal of the American Medical Association, 1937) discuss the case of a white male of forty-seven, who had a chancre at eighteen and was known to have had positive serology at 32 years, followed by inadequate treatment. Eleven years later he began having exertional pain with dyspnoea, followed by morphine addiction with the intravenous administration of non-sterile preparations. Seven months before his admission with bacterial endocarditis he was known to have aortic insufficiency. Section showed vegetative aortic lesions with extension to the mitral, syphilis of the aorta and aortic valves, and a post-mortem culture of hemolytic staphylococcus aureus.

Smith (International Clinics, 1937) reviewed 193 cases of bacterial endocarditis from the Henry Ford Hospital and found three which were of interest in reference to the coexistence of the lesions. The first, a white male, with an acute febrile

illness, aortic insufficiency, purpura and petechia, positive serology, and a positive blood culture of staphylococcus aureus, showing anatomically ulcerative vegetations involving the tricuspid, mitral and aortic valves, but with otherwise normal aortic valves. Second, a white male of sixty-three years, who had developed a urinary tract infection secondary to a cord bladder of pernicious anemia, and who later showed evidence of a staphylococcus albus septicemia. He had positive serology but the clinical evidence of aortic insufficiency was questionable. However, autopsy showed typical changes in aortic cusps and friable vegetations. The third case was that of a thirty-nine-year-old white male who had had primary syphilis at eighteen years of age, followed by one year of treatment. Six months before his final admission he had a chronic infection of the left hand requiring numerous incisions, and it was found on general examination at that time that he had an aortic insufficiency with positive blood serology. Three months later signs and symptoms of a septicemia appeared and he had positive blood cultures for streptococcus viridans. Autopsy showed stenosis and insufficiency at the aortic orifice with vegetations, but the valve leaflets were calcified and showed no syphilitic change, though syphilis of the aorta was present. Smith felt this favored an old rheumatic aortic lesion and concluded that only the second of his cases would be acceptable as fulfilling the criteria.

Martin and Adams, in the American Heart Journal, 1938, reported an investigation of 157 cases of bacterial endocarditis at the Los Angeles County General Hospital, and thought that five could justifiably be accepted as evidence of infective endocarditis on syphilitic valve disease. In two of these cases, while syphilitic aortitis was present, one with vegetations on the aorta distal to the valve, neither showed classical valve changes; and in a third, rheumatic mitral and aortic changes were highly suggestive. Therefore, only two of these would seem of value.

Thus, it would seem that there have been only eleven cases reported in the literature in which with reason one might conclude that a pre-existing syphilitic lesion of the aortic valves formed the base upon which a secondary infection might have become implanted, and two in which a syphilitic aortitis was present upon which vegetations had developed, but which showed no valvulitis. It is

also of interest that these reports have all appeared within the last twenty years, and about half in the last five. This suggests an increasing interest in the subject and the possibility that the occurrence of these two disease processes in the same individual is more frequent than has been thought.

Various theories have been offered as to the lack of association of bacterial endocarditis with syphilitic valvular disease, and its frequent occurrence with rheumatic valvulitis, but here one finds very contradictory comment. Cotton and Briggs each suggest the more common finding of rheumatic lesions under thirty-five years of age and syphilis over thirty-five. This, coupled with the tendency for bacterial endocarditis to occur in the earlier decades, favors the former association over the latter. They also think that the rheumatic valve is the more vascular of the two, increasing the possibility of local embolic phenomena. This theory was given support by the early work of Bayne-Jones on the vascularity of the mitral valve and the embolic theories of Koster and Rosenow.

Craven and others think the syphilitic valve is really quite vascular, so that vascularity could not play a part, and this in more recent years has been given general acceptance. Still other writers, on reviewing the case reports of the association of syphilitic valvulitis and bacterial endocarditis, do not consider it significantly limited to any age group, nor do they feel that there is any evidence favoring the embolic theory.

Another suggestion is that the original deformity of the mitral valve follows a non-hemolytic streptococcus infection, with the organisms lying dormant for some time, subsequently flaring up to produce the vegetative lesions. This idea, that rheumatic valvular changes are streptococcal in nature, has never been satisfactorily supported. Gallavardin and Jouve think that the smoothness of the syphilitic valve as compared to the roughness of the rheumatic makes the latter more liable to infection, and they consider the necessity of the development of a fissure on the syphilitic valve before infection can take place. This is advocated by other French authors.

It has also been proposed that the development of valvular vegetations is the result of local stress and strain, making already diseased valves a more likely seat for the implantation of infections. As the point of greatest stress is most apt to occur along the margins of the mitral valve, rheumatic

changes there tend to make vegetations occur most commonly in this location. Because syphilis attacks the aortic cusps along the line of their attachment to the aorta, resulting later in retraction of the valve edges, and with the greatest strain occurring at the valve base rather than at the margins, the syphilitic aortic valves would seem a less satisfactory foundation for vegetative formations. This difference may account for the less frequent occurrence of vegetative endocarditis on a syphilitic basis and would seem to be the most acceptable of the theories proposed.

The autopsy protocols at the Baltimore City Hospitals have been investigated and it was found that among 8,100 cases, there were 105 of bacterial endocarditis, acute and subacute. Of these, fourteen were felt definitely to be satisfactory examples of vegetative bacterial endocarditis superimposed on old syphilitic aortic valve disease. However, because of lack of suitable material for further microscopic study, eight cases were discarded. The remaining six cases are being reported in complete detail, clinically and pathologically, by Braunstein and Townsend in a forthcoming issue of the Archives of Internal Medicine. They establish rigid criteria for their selections in order to obtain unimpeachable cases. In all there was a history of syphilis, positive serology or a history of anti-syphilitic treatment. In addition, there had to be gross and microscopic evidence of syphilis of the aortic valve cusps and aorta, the absence of changes in any valve suggesting other pathological processes, especially rheumatic disease, the vegetations described and located, and bacteria demonstrated. Care was taken to exclude cases of terminal bacterial infection of the blood stream—so-called terminal bacterial endocarditis.

No attempt is to be made here to give the case reports in detail, but only to point out certain features that might be of interest with reference to the other cases and the comments and theories previously mentioned.

Of the six proven cases, all were negroes, five males and one female. The ages ranged from 30 to 44 years; three in the fourth and three in the fifth decades. In none was there any history suggesting any of the characteristics of the "rheumatic syndrome" having occurred earlier in life. In one there was a history of previous anti-syphilitic treatment, and in another, a questionable primary lesion; but in the other four cases no information

was obtained suggesting a previous syphilitic infection. Only two of the cases had known syphilis prior to admission, or symptoms suggesting longstanding cardiac disease; one who had had to stop work three years before admission because of gradually increasing exertional dyspnoea and some oedema, and had been told that he had heart trouble. A second had evidence of an aortic insufficiency on admission to the hospital because of an hemiplegia in 1924, but whose terminal illness did not occur until 1935.

The onset of symptoms could be considered quite acute in only one instance. The duration of symptoms that could probably be attributed to the bacterial infection before admission varied between seven days and eighth months, the period of hospitalization before death between two days and two months, and the entire course of illness being nineteen days, two months, three months, two months, seven months, and eight months respectively.

Admission temperature elevations were significant in two, one with 103° who had a lobar pneumonia, and a second with 102.4° ; the others having elevations of not more than one degree, but all subsequently showing fever of a septic type with peaks from 102.5° to 104° . Chills were not a feature in any case.

Five of the six patients showed rather marked cardiac enlargement on preliminary examination, four had aortic diastolic murmurs and a fifth developed one during the course of the illness. The first five had definite or suggestive Corrigan pulses substantiated by blood pressure determinations. The sixth case, admitted because of a lobar pneumonia, showed no cardiac enlargement, had no murmurs or Corrigan pulse, and had a blood pressure of 155/100. All except this last showed marked congestive changes.

Splenic enlargement was noted in only one case. Petechia were not seen clinically in any instance, nor were there any embolic phenomena which could be attributed to the breaking off of vegetations.

In four cases blood cultures were not taken because bacteremia was not suspected, in the fifth three taken were reported negative, and in the sixth the culture was positive for pneumococci. Four cases showed admission anemia—average red counts 3.2 million and hemoglobin 60%, but two had essentially normal blood counts and hemoglobin. The leucocyte counts varied greatly and could not be considered as being significant. Urinary findings were not striking; albuminuria com-

patible with the degree of congestive failure or the febrile state was found, and in no instance was microscopic hematuria noted. Five of the cases had strongly positive blood Wassermans; the sixth being the patient who had had anti-syphilitic treatment.

Sections showed all of the cases to have fulfilled the previously established criteria. In each there was gross and microscopic evidence of syphilitic aortitis and valvulitis. All had fresh and some healing vegetations on the aortic valve cusps with extension in several cases to the mitral leaflets. These, however, were felt to have shown no evidence of pre-existing disease. Micotic aneurysms of the aortic cusps were noted in several. Insufficiency of the aortic valve was present in each case, that of the pneumonic patient being the least significant. In each there was evidence of left ventricular hypertrophy, as well as some dilatation, favoring the existence of a valvular lesion for a considerable period. Three of the cases showed acute splenic tumors, three septic infarcts of the kidneys and one of the lungs. Microscopic examinations of the sections through vegetations and valves after bacterial stains, demonstrated the presence of pneumococci in the case of lobar pneumonia and "Gram positive cocci" in the other five. This, then, adds six new cases of the two disease processes occurring in the same individual, and the largest number to be reported from a single source, to the eleven previously reported acceptable ones, making a total of seventeen. In general, the points of interest in this series correspond to those in the literature.

The largest number of cases occurred between the ages of thirty and forty-five years, the average age being somewhat higher in the white race. Fifteen were in males and two in females; a finding compatible with the occurrence of uncomplicated syphilitic aortitis and valvulitis, but a much higher ratio than usually occurs in bacterial endocarditis.

All of our cases were negroes, the others two negroes and eight whites, the race of one not being known. This racial preponderance is probably accounted for on the basis of the tremendous number of negro patients with cardio-vascular syphilis admitted to the Baltimore City Hospitals. The duration of illness in our patients between probable onset and death ranged from three weeks to eight months, four being under three months, suggesting a more rapidly progressive disease, even when of the subacute type, than is usually thought of in

connection with bacterial endocarditis. This was substantiated in the other series.

Chills or chilly sensations were not a characteristic feature in any of the seventeen. Fever was not significant on admission, except in one case, other than the pneumonia, but developed in the intermittent form during hospitalization. Petechia were strikingly absent, as well as clinical palpability of the spleen. Hematuria and evidence of acute glomerular nephritis, commonly expected phenomena in bacterial endocarditis, were conspicuous by their absence; none having been noted in our series. Embolic phenomena with their clinical manifestations were very few in the total seventeen, and none in ours. In general, the degree of anemia was not as profound as might be expected in the terminal stages of this type of infective process. It seems probable that the organism responsible in most instances was the streptococcus viridans; two were caused by staphylococcus aureus, one staphylococcus albus, and one pneumococcus.

Serology was positive in all cases but two, and they had given satisfactory histories of anti-syphilitic treatment. In this connection, it is of interest to note that several authors mention the possible occurrence of a positive Wassermann in the course of bacterial endocarditis. This assumption is based upon a negative history of syphilis or of any demonstrable clinical or pathological evidence of the disease and cannot be accepted as a valid observation.

It is of importance that none of our cases was suspected clinically of having had bacterial endocarditis. This may have been responsible in some instances for the failure to observe some of the more classical clinical signs of this disease; as, for example, petechia, splenic tumor, hematuria, etc. Five of the patients were admitted in rather marked cardiac failure, and the sixth with lobar pneumonia, and these features apparently overshadowed the existence of the bacterial endocarditis. These circumstances, coupled with the fact that most patients with extreme congestive pulmonary changes tend to run a febrile course and have a terminal bronchopneumonia, probably led the observers to discount the significance of the fever and made the clinical diagnosis of bacterial endocarditis more difficult. The rather rapidly progressive cardiac failure in these cases is not untypical of that seen in the average case of aortic insufficiency, in which, when break does occur, there is failure to respond to the usual therapeutic measures.

Clinical diagnosis of the association of bacterial endocarditis with syphilitic valvular disease is at best difficult, but should be suspected in any case of supposed syphilitic aortic insufficiency which runs a continuous febrile and progressively downhill course, especially if any of the usually associated classical signs, such as progressive anemia, etc., are present. However, definite diagnosis can be made only after careful anatomical study, not only for positive features, but to rule out other conditions which might produce the primary valvular change.

We present, then, a review of eleven previously reported cases, add six more, and suggest the possibility that the conditions mentioned occur with more frequency than has been thought and should be searched for more carefully.

THE MEDICAL MANAGEMENT OF GASTRIC AND DUODENAL ULCER

Newer Aspects

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There are few chronic disease entities which are of such great interest and importance and which continually arouse so much controversial discussion as peptic ulcer. This is due to the fact that the true etiology and pathogenesis of gastric and duodenal ulcer are still unknown. However, from all investigations it appears evident that peptic ulcer is essentially a disease of civilized man and is prone to occur in individuals of dynamic or hyperemotional character. It is in reality a local complication of some progressive systemic or constitutional disturbance of varied etiologic origin and is featured by periods of remissions and recurrences. It is, therefore, imperative to recognize that successful management of gastric and duodenal ulcer, by whatever means, must include not only the treatment of the local condition, but most important of all, the individual who harbors the ulcer. It may rightly be stated that the life cycle of ulcer in an ulcer bearing individual, ends only with the life of the individual.

Read at the meeting of the Providence Medical Association, November 6, 1939.

Before planning any management or therapy, it is important to determine definitely whether an ulcer really exists and if so, of what variety. The most valuable single method of examination that we possess is competent roentgenography for both diagnosis and as a guide in treatment. Its value, however, as a diagnostic procedure is greatly enhanced when we use it in conjunction with other tests and a carefully obtained history. In the history, we should strive to discern in the most thorough manner the emotional life of the patient, his manner of living, his domestic and business problems. Inquiry should also be made regarding the character of the disease: its duration, nature of pain or distress, time of its occurrence, remissions, persistency, any recent change of symptoms, the means by which the pain is relieved, especially whether the pain is severe enough to require the administration of an opiate. A careful physical examination, gastric analysis, stool examination, blood studies, urine analysis and basal metabolic studies are all of great importance in completing our data both for diagnosis and in the successful management of the patient. With the recent introduction of the Schindler flexible gastroscope we have an additional valuable diagnostic approach in experienced hands.

There should be a thorough understanding and complete cooperation between the patient and the physician in order to obtain true and lasting benefits from any therapy. We should consider the patient's ulcer just as if it were our own, and in that spirit of understanding and cooperation outline the treatment. Another very important requisite is that there should be true cooperation and genuine teamwork between the surgeon and the clinician in the successful handling of these cases both preoperatively and postoperatively. Let us bear in mind that peptic ulcer is essentially a chronic disease with frequent remissions and recurrences, and is primarily a medical problem which at times may require the aid of surgery. We may consider peptic ulcer analogous to diabetes and pulmonary tuberculosis, chronic disease entities subject to periods of quiescence and recurrences, treated successfully by medical means, but which on certain occasions require the aid of surgery.

Having made an accurate diagnosis of the presence of an ulcer, the question then arises, "What are the best means of its management?" Duodenal ulcers do better under medical management than gastric ulcers and cause less apprehension from the

possibility of malignant degeneration. The best cases for medical management are young patients with histories of short duration, short attacks, long periods of remissions, absence of complications and most important of all, those individuals possessing intelligence and a spirit of true cooperation with their physician.

The most important problems for our consideration in the management of peptic ulcer are the following: What is the nature of the ulcer? Is it a gastric or a duodenal ulcer? Is it acute or chronic? Is it a perforating or a penetrating lesion? Is there a history of bleeding? Any suspicion of malignant degeneration? The presence of an hour-glass contraction of the stomach causing symptoms, or the presence of a true pyloric obstruction due to cicatricial contraction? Recurrences of severe symptoms after the patient has been under adequate, competent and prolonged medical management and the development of an intolerance to alkali therapy are significant.

As the causes of gastric and duodenal ulcers are not definitely known, our treatment must essentially be symptomatic. There are two chief problems in therapy (1) to promote the healing of the lesion present and (2) to prevent its recurrence. This is accomplished by having the patient follow a definitely prescribed regime: avoiding physical as well as mental fatigue and emotional upsets; adhering to a definite dietary plan. The diet should consist of bland foods of adequate caloric value, vitamin and mineral salt requirement, non-stimulating to acid secretion and fed regularly at frequent intervals in small amounts. Alkali therapy may be necessary in some cases to control hyperacidity; when there is an intolerance to alkalies, substitutes may be used. Among these, the most valuable are colloidal aluminum hydroxide and magnesium trisilicate, which act as buffers. Antispasmodics and sedatives are very valuable adjuncts to control pylorospasm or hypersecretion. Bismuth and olive oil may be used to some advantage. If anemia is present appropriate treatment should be prescribed. Tobacco should be used only very sparingly in the milder and arrested cases and should be absolutely prohibited in all others. In severe cases, rest in bed for several weeks is an important adjunct to successful therapy. Foci of infection, when found, should be eradicated without any undue delay.

During the periods of quiescence, the patient should be impressed with the importance of complete cooperation and strict adherence to his ulcer

regimen. He should be warned that neglect will bring on not only a recurrence but the additional hazard of complications. An individual harboring an ulcer must be impressed with the great importance of avoiding mental and physical strain, infections, breaking his dietary regimen, overeating, alcohol, and the excessive use of tobacco. He should bear in mind the importance of a peaceful mind and rested body to good digestion. He may well remember the saying in the Proverbs, "Better is a dry morsel and quietness therewith, than a house full of feasting with strife."

Since one of the chief objectives in medicine is the prevention of disease, the importance of educating people to the appreciation of the seriousness of gastric and duodenal ulcer and its prevention is increasingly apparent. People should be warned that attacks of recurrent indigestion, no matter how mild they may be, should not be treated lightly. They should seek competent medical advice without any undue delay.

WHAT ARE THE ADVANTAGES AND DISADVANTAGES OF MEDICAL MANAGEMENT?

There is practically no mortality and the large majority of patients may be treated in an ambulatory manner. Only the severe, complicated cases require hospitalization. Of economic importance to the patient is the loss of time from his occupation or business and the increased expenditures that bed rest or hospitalization entail. Statistical studies show that the ultimate result is identical in ambulatory and hospitalized cases. Most ulcer patients are otherwise healthy and in such good physical condition that they do not readily agree to bed confinement as a requisite to successful therapy. Constant occupation or employment is a great help to prevent self-pity and the development of a condition of psychoneurosis which frequently occurs in patients with gastro-intestinal complaints. About 70 per cent of duodenal ulcers and about 60 per cent of gastric ulcers are "cured" and from 20 to 25 per cent may be markedly improved under adequate medical management. Means¹ states that at the Massachusetts General Hospital only about 10 per cent of all patients with duodenal ulcer and 30 to 40 per cent with gastric ulcer ultimately come to surgery. These figures refer specifically to hospitalized patients.

The danger of cancer developing at the site of a gastric ulcer is in reality not very great. By means

of frequent Roentgen ray studies of the ulcer and examination of the gastric content and of the feces we may obtain valuable information in the progress of the healing of the ulcer. We have several criteria that must be fulfilled during a trial period of several weeks of observation in order to rule out malignancy. The X-ray appearance of the ulcer crater or defect must either completely disappear or must show a marked progressive diminution in its size. Examination of the gastric content and stool should show a disappearance of occult blood. All symptoms must disappear within a period of about 4 weeks, otherwise surgical intervention is in all probability indicated.

In a personal series of 57 patients with gastric ulcer seen over a period of fifteen years, I have observed but two cases of carcinoma developing at the site of an ulcer, (1) in an old man who was operated two years previously for a perforated duodenal ulcer, and at the operation it was found that he had also a gastric ulcer; (2) in a man, age 70, who had a diaphragmatic hernia and later developed a gastric ulcer. Three years later he died of cancer of the stomach which had developed at the site of his old ulcer.

Pyloric Obstruction

Chronic pyloric obstruction is one of the most recognized and accepted indications for surgery. In these cases surgical intervention gives excellent results. But, before we definitely decide that surgical intervention should be resorted to, it is important that we should be sure that the obstruction is due actually to scar tissue formation and not to pylorospasm, infection, or oedema from the ulceration. The age of the patient, the duration of symptoms, his general condition and blood studies are all important factors to be considered in this connection. In a series of about 650 duodenal and 57 gastric ulcers seen in private practice, I have often observed the presence of pyloric obstruction which in some cases showed a 75 per cent gastric residue after twenty-four hours. Treated medically, in nearly all instances, the obstruction was relieved and the patients remained free of symptoms over a period of three to five years. I have had but 6 cases which required surgery.

Since many ulcer patients with pyloric obstruction have had their lesions for many years they evidence profound nutritional deficiencies, such as, marked dehydration and anemia due to either poor utilization of food, to restricted diet, or to repeated attacks of vomiting. Their blood may show many

abnormal changes and the kidneys may show impaired function. Vitamin C depletion is also frequently present. The object of treatment in these obstructed cases is to restore the chemical balance of the body to as near normal as possible. In severe cases, this requires hospitalization with complete bed rest and a dietary regimen compatible with the condition of the patient. Alkalies must be used cautiously, because of the danger of alkalosis. It is therefore very important during this management to have frequent blood chemistry studies made. Gastric aspiration and lavage is performed as often as necessary.

Procedure for Treating Pyloric Obstruction and Intractable Cases of Peptic Ulcer

In the past five years I have treated a series of obstructed cases with total abstention from food over a period of five to ten days. During this period gastric aspiration and lavage is done, antispasmodic and sedative drugs are administered either hypodermically or rectally. Vitamin C in the form of calcium cevitamate is administered hypodermically and glucose and saline are given intravenously, and when necessary a transfusion is done to help restore low plasma protein. Within several days, these patients become symptom free and are markedly improved and develop a sense of well-being. Following this period, they are fed continually day and night for a period of from ten days to two weeks, through a Levine drip tube, intragastrically. They are given a mixture of milk and cream to which has been added either aluminum hydroxide or alkalies. With improvement the patient gradually resumes his prescribed diet. This procedure I have found not only valuable in cases of pyloric obstruction but also in intractable cases of peptic ulcer where many other forms of therapy have failed. I deem it a valuable procedure to bear in mind.

Gastric Hemorrhage

Bleeding in variable amounts may occur at times in most cases of gastric and duodenal ulcer. Occult blood may be found in either the gastric content or stool, or in both. However, gross hemorrhage is comparatively rare, estimated by different authorities to be approximately 5 to 10 per cent. Crohn² in a series of over 100 cases of acute gross hemorrhage encountered a mortality as low as 4 per cent and concludes that since only 25 per cent of ulcer cases bleed this gives a total mortality of hemorrhage in ulcer of less than one per cent. He therefore warns that there should not be so much panic

over gross hemorrhage. He advocates conservative treatment. It is better to accept defeat in 4 per cent than to be panicky about 96 per cent and take a radical position of advising operative treatment during hemorrhage.

In my series there were 52 cases of severe gross hemorrhage. All were treated conservatively without a fatality. Most eminent surgeons and internists agree that for the patient's best interests, medical management is much safer than surgery immediately after gross hemorrhage. There is also a good possibility that the patient, after his recovery, will never again have another hemorrhage. On the other hand, in cases of severe repeated hemorrhages from the stomach or the duodenum, in patients who have had adequate and competent medical management, or in patients past 50 when arteriosclerosis becomes an important factor, surgical intervention is indicated, after the patient has been properly prepared. To advise surgery in every case of gross hemorrhage would be hazardous. The best method of preventing the recurrence of hemorrhage is by sub-total gastrectomy, which carries a high mortality if performed by the average surgeon.

The medical treatment of hemorrhage consist of absolute rest, abstinence from food for a day or two and the administration of morphia and sedatives as needed, for the complete comfort of the patient. The parenteral or intravenous administration of glucose and saline best given slowly or by the drip method; and if the condition of the patient necessitates it, a blood transfusion should be given in the same manner without undue delay. Several small blood transfusions given slowly by the drip method are not only beneficial in restoring blood volume and hemoglobin concentration, but also help to shorten the convalescence of the patient. The danger of increasing hemorrhage by raising the blood pressure by transfusion is practically nil if given by the slow drip method. The patient may be allowed food cautiously after the cessation of bleeding, and his food intake is increased daily without undue delay. Within five to seven days after the cessation of hemorrhage, the patient should be on a diet of high caloric value rich in animal protein and in vitamins, especially vitamin C. Iron in some palatable form is also added.

Recently some clinicians, encouraged by the work of Meulengracht³ (his diet consists of pureed and soft foods with the free administration of alkalis. Dinner alone includes meat balls, broiled chops,

omelette, fish balls, vegetable soup, stewed apricots, apple sauce, "the patients eating as much as they want") who reported a mortality between one and two per cent by feeding patients with a liberal diet during and immediately after bleeding, have attempted to carry out the same procedure, but with much less encouraging results.

Acute perforation of a gastric or of a duodenal ulcer is of course an absolute immediate indication for surgery. Any delay before surgical consultation may end in catastrophe. However, the best teamwork should be displayed between the internist and surgeon in the preoperative and postoperative management of the patient in order to secure best results.

Perhaps a few brief remarks evaluating some of the aspects of the newer methods of treating gastric and duodenal ulcers may be pertinent. Just as the surgeon has turned from the usual orthodox gastroenterostomy to many other procedures, namely Finney or Horsley pyloroplasty, fundusctomy, sleeve resection, V-shaped excisions, pylorectomy, Balfour excision and cauterization with and without gastroenterostomy and finally and at long last is now advocating strongly partial and subtotal gastrectomy, in the hope that this may result in more permanent cures without complications, so the medical man has also attempted many new forms of therapy in addition to the usual orthodox treatment as advocated by Sippy and others. Of the latest, we have the following: mucin, vaccines, non-specific proteins, synodal, larostidin or histidine, endocrine products, Roentgen therapy and many others. Theoretically mucin should be a valuable adjunct in treating these cases but practically it is found to be rather expensive, unpalatable to take, and in patients with renal disease it has been shown to aggravate the condition. Vaccines, nonspecific proteins, synodal, endocrine products and especially larostidin (which has been hailed during the past few years as a dramatic, spectacular cure of ulcer) have been found by careful observers to be of no real lasting value. Sandweiss,⁴ who investigated the use of larostidin, states, "It is my impression that the psychic factor plays an important role. The physician, in order to justify ten or fifteen or twenty-five injections must of necessity also inject into the patient's mind certain elements favorable to the treatment. He must tell the patient that the parenteral method of treatment is a new treatment, that eminent physicians the world over have reported successful results with its use, that the

patient may be able to follow a more balanced diet, etc., etc. These encouraging statements to my mind play a great part in the results obtained." My own observation has been similar.

Summary

Gastric and duodenal ulcer are primarily chronic recurrent medical disease entities of civilized man prone to occur in individuals of dynamic or hyper-emotional character. During their life cycle, complications may arise when surgical intervention may be necessary. Good results may be obtained under adequate medical management in the large majority of cases. In only a small number of patients may surgical intervention be an absolute indication as an adjunct to the management; these indications are definite and are: perforation, true cicatricial pyloric obstruction, repeated massive hemorrhages endangering the life of the patient, intractable ulceration or a suspicion of gastric malignancy. A valuable procedure in the management of pyloric obstruction and of intractable cases of peptic ulcer is described. People should be warned that attacks of recurrent indigestion, no matter how mild they may be, should not be treated lightly. They should seek competent medical advice without any undue delay. True cooperation and genuine teamwork between the surgeon and internist is absolutely essential as in diabetes and pulmonary tuberculosis. A person harboring an ulcer must be thoroughly convinced to treat his ulcer with respect and not abuse it with alcohol and tobacco; by overeating, or by the ingestion of indigestible food or irritating drugs, and above all, to avoid emotional upsets and physical strain. Finally, as has been stated in the introductory remarks, in order to treat a peptic ulcer as successfully as possible, the physician must treat his patient's ulcer as if it were his own, remembering that the life cycle of ulcer in an ulcer bearing individual, ends only with the life of the individual.

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THE RHODE ISLAND MEDICAL JOURNAL

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NUMERICAL HOSPITAL RECORDS

The clinical record, presenting an intimate account of the patient's condition and of his treatment in the hospital, is filed in the record room on his discharge from the hospital. These filed records have their value for future reference to the history of the individual patient, for collecting statistics of the work of the hospital, and as a source of data for scientific study of conditions, methods of treatment and results. There are several systems of filing hospital records, each of which presents certain advantages.

Records may be filed alphabetically by the names of patients. This method may be satisfactory for a few records but in a large series names are so often duplicated that a numerical designation becomes necessary; there will be John Smith, No. 1, 2, 3, 4, and 5. While an alphabetical list of names is essential in a record system, it is better arranged in a cross index with references to the records filed by a numerical system.

Records may be filed by diagnosis according to the chosen system of nomenclature. This method has the advantage of ease in collecting data for an annual report and for scientific study. For often

repeated diagnoses a numerical designation is required; there will be Appendicitis No. 1, 2, and 3, to hundreds. Any change in the system of classification will require a corresponding change in the filing system. While an index of diagnoses is essential for a hospital record system, it is better done in a cross index with references to the records filed by a numerical system.

Records may be filed by date of admission or of discharge. This method duplicates the lists kept in the admission and discharge books and has no apparent advantage.

Records may be filed by admission number. The consecutive admission number is a very important feature of a hospital record system. It is applied immediately on the patient's admission to the hospital. It appears on the history charts from the time of his admission to his discharge from the hospital. It identifies the patient and his history and tends to prevent mistakes in identity which have sometimes been the cause of near-tragic mistakes. It is the connecting link between the records of the out-patient, the X-ray, the pathologic, and other minor departments. It facilitates coordination of the records of these departments with the main record system. But when the treatment is concluded, the final diagnosis made, and the history charts collected for transmission to the record room, the mission of the admission number is completed. Records may be filed by admission number but filing by consecutive discharge number has distinct advantages.

The discharge number is taken from the discharge book at the time when the patient leaves the hospital. Records come to the record room in the order indicated by the discharge numbers. Of two patients admitted today, one may be discharged tomorrow, the other not for a month. Filing by admission number requires keeping the record of the first patient until the second one has been discharged before the first can be permanently filed. Further than this, the diagnosis on discharge and not the provisional admission diagnosis must appear in the diagnosis index. Filing by discharge number seems the natural method for filing the case histories in the record room. The method leads readily to the use of a follow up system.

Subtracting the last discharge number from the last admission number gives the number of patients in the house at any time. Comparison of this number with the number obtained by actual count checks the accuracy of the system.

When a patient who has previously been treated in the hospital is readmitted, his history may be taken from the file to form a part of the subsequent record and a note to that effect left in the file. In this way there is a continuous record of the patient's condition and treatment without interference with the operation of the system. In some cases it may be preferable to include an abstract of the previous history with the subsequent record.

The record room need have no interest in the patients who are still under treatment in the house. It should have a complete record of the work done in any department of the hospital for every patient who has been discharged.

PHYSICIANS ON POSTAGE STAMPS

On April 8 the Post Office Department puts on sale a two-cent postage stamp with a likeness of Dr. Crawford W. Long, in his honor as the Discoverer of Anesthesia. This is comforting to people in Georgia, Dr. Long's home state, but disturbing in Connecticut, where Dr. Horace Wells is the Discoverer of Anesthesia, in Massachusetts where Drs. Charles T. Jackson and William T. G. Morton vie for the honor, even in Edinburgh where Sir James Y. Simpson is honored as the great discoverer. In fact, neither Long, Wells, Jackson, Morton nor Simpson can properly be called the Discoverer of Anesthesia. The word had its origin in a letter of one Oliver Wendell Holmes on November 21, 1846. It was first practically used in an article published by Simpson in 1847.

Long had given ether for a surgical operation on March 30, 1842. Wells inhaled nitrous oxide for extraction of a tooth on December 11, 1844. Morton gave a successful demonstration of insensibility to pain for a surgical operation on October 16, 1846. Simpson overcame ethical and religious objections to relief of pain by administering chloroform to the Queen of England. None of these men invented ether, nitrous oxide, chloroform, or discovered the word Anesthesia. Neither Long, Wells or Morton seems to have appreciated the tremendous implications of their work. But Morton's friends and associates in Boston gave his work the publicity which spread the idea of insensibility to pain throughout the civilized world with speed unparalleled in the history of great discoveries. Yet in Paris Valpeau refused to try ether, doubting its

efficiency in destroying sensibility. At the Pennsylvania Hospital, in Philadelphia, as late as November 2, 1847, it had not been tried at all. Inevitably, to no one man can be given the entire credit for the greatest of medical discoveries.

PROVIDENCE MEDICAL ASSOCIATION

February Meeting

The regular meeting of the Providence Medical Association was held at the Medical Library, Monday, February 5, 1940. The meeting was called to order by President Walsh at 8:40 P. M. The minutes of the preceding meeting were read by the Secretary and were accepted as read. The Secretary reported for the Executive Committee that:

(1) The President had been empowered to appoint a committee of five to investigate Contract Practice in the district.

(2) That the Executive Secretary had filed with the House Corporations Committee of the General Assembly the recommendation of the Executive Committee of the Providence Medical Association that the proposed new city charter be worded to provide that the Mayor shall appoint a superintendent of health who shall be a doctor of medicine, and who shall have either a doctor's degree in public health or a minimum of five years' experience in the administration of public health, and further that the term of office be changed to read for six years instead of two years as now proposed.

(3) That a motion had been passed that the Basic Science Act, in the form in which it had been admitted at the General Assembly last year, be approved by this Association and that the Act be recommended for passage by the General Assembly this year, and further that a resolution be prepared to this effect, and said resolution transmitted to the General Assembly of Rhode Island.

The report of the Executive Committee was approved and placed on file.

The President reported that the obituary of Dr. J. P. Lobo, prepared by Drs. H. C. Messinger and James Londegan, was to be on file with the Secretary.

The Secretary reported that the Executive Committee recommended the application for membership in the Association of Dr. Hampartsum S. Gulesserian. On the motion of Dr. Mowry, the application was accepted.

The President called for resolution on the Basic Science Act which was presented by Dr. Guy Wells as follows:

Whereas, The obligation of the medical profession is to safeguard the health of the citizens, and

Whereas, the medical Profession of Rhode Island has always advanced legislation which is for the best interest of the people and their health,

Therefore, The Providence Medical Association, in meeting assembled, endorses fully the amended Basic Science Act proposed to the present session of the General Assembly as an Act directed toward the better protection of the health of all in Rhode Island, and

Further, This Association urges that this Act be given full and favorable consideration by the Legislature in its present session.

On the motion from the floor the resolution was accepted.

The President explained the action of the Executive Committee relative to the recommendation made the General Assembly regarding the Health Department provision in the proposed city charter. Dr. Herbert Partridge moved the acceptance of the action of the Executive Committee and moved that the Association reaffirm this action. Dr. Frank Cutts seconded the motion. Motion passed unanimously.

The business of the evening being completed, the President introduced as the guest speaker Dr. Louis K. Diamond of Boston, Mass., who spoke on the subject, "Treatment of Anemias in Infancy and Childhood With Special Reference to Splenectomy." Discussion of Dr. Diamond's paper was given by Dr. Frank Cutts and Dr. Emanuel Benjamin.

The meeting was adjourned at 10:20 P. M. Attendance 130. Collation was served.

Respectfully submitted,

HERMAN A. LAWSON, M.D., *Secretary*

RHODE ISLAND HOSPITAL

Dr. John A. Dillon (Holy Cross 1934, Yale Medical School 1938) finished a shortened rotating internship on March 1st, 1940. Five months of his appointment were left unfinished in order that he might accept an internship in Internal Medicine at the Peter Bent Brigham Hospital, in Boston.

Dr. John H. Meany (Holy Cross 1932, McGill Medical School 1937) is serving the last five months of Dr. Dillon's appointment. Dr. Meany served at the Royal Victoria Montreal Maternity Hospital and the regular rotating internship at Worcester City Hospital before coming to Rhode Island Hospital.

Dr. Walter F. Fitzpatrick, Jr. (Providence College 1933, Georgetown Medical School 1937) finished the regular rotating internship on March 1st, 1940. He is now Resident Admitting Physician at the Hospital. On July 1st, he will start his service as Resident Physician in Medicine.

Dr. Luther R. Lewis (Brown University 1935, Harvard Medical School 1939) started the regular rotating internship on March 15th, 1940.

The general residency, begun in 1923, has been discontinued. In its place the hospital now offers a Residency in Internal Medicine of one year's duration beginning July 1st of each year.

A new appointment which has recently been established is that of Resident Admitting Physician. The duties of the appointee are to be responsible for medical judgment in the treatment of accident cases and the admission of all patients. This appointment should prove to be an attractive one. The business side of the Accident and Admitting Room is the responsibility of Dr. Asa S. Briggs.

CHARLES V. CHAPIN HOSPITAL

Dr. David J. Fish left on February 29 to commence a service at the Worcester City Hospital. He was an intern here since the first of October. To fill the vacancy, Dr. Olga S. Wermer was appointed. She is a graduate of the Universities of Vienna and Lausanne and her husband, Dr. Henry Wermer, is now a resident physician at the State Hospital for Mental Diseases.

Dr. Linus A. Sheehan and Dr. Luther R. Lewis each completed an internship of five and one-half months on March 15. Dr. Lewis is starting an internship at the Rhode Island Hospital and Dr. Sheehan, after a month at the Providence Lying-In Hospital, will begin his Rhode Island Hospital internship on April 15.

After an internship of three months, Dr. Peter A. Perillo left on March 31 to start a residency in pediatrics at the Long Island College Hospital.

THE MEMORIAL HOSPITAL

Pawtucket, R. I.

Schedule Beginning April 1, 1940

Medical Service:

Medical Ward Rounds at 11:00 A. M. every Saturday.

Medical Symposium on the last Friday of each month in the Nurses' Home Auditorium at 11:30 A. M.

Clinical Pathological Conference:

April, 10, 1940, at 12:00 Noon.

Surgical Service:

Surgical Pathological Conference on the second Wednesday of each month at 11:30 A. M.

Surgical Ward Rounds at 11:00 A. M. every Wednesday.

Surgical Conference on the first and third Wednesdays at 12:00 Noon in the Tumor Clinic Room.

Tumor Clinic:

The first and third Thursdays of each month at 10:00 A. M.

Urological Service:

Ward Rounds at 12:00 Noon on the first and third Mondays of every month.

Medical Staff Meetings:

Meeting of the entire staff on the second Wednesday of each month at 1:00 P. M.

Obstetrical Service:

Conference on the last Friday of each month at 12:00 Noon.

Orthopedic Service:

Ward Rounds at 8:30 A. M. every Monday.

Pediatric Service:

Ward Rounds and Discussion of Cases at 12:00 Noon every Thursday.

Ear, Nose and Throat Service:

Ward Rounds and Discussion of Cases at 10:30 A. M. on the second Wednesday of each month.

Members of the staff and physicians who are not on the staff are cordially invited to participate in the various activities such as ward rounds. The above schedule and subsequent ones will be printed in the RHODE ISLAND MEDICAL JOURNAL so that you may be acquainted with the various dates. By presenting yourself at the information desk in the Main Hospital, you will be directed to the various departments where such activities are taking place.

Births: A son to Ralph J. Petrucci, M.D.

Frank E. Hanley, M.D., is convalescing at home following an appendectomy. Albert J. Gaudet, M.D., has resumed his practice after having had an appendectomy.

A clinical pathological conference was held at this hospital on March 13, 1940. Dr. Earl F. Kelly presented a case of tuberculosis meningitis which was discussed by Drs. Feinberg, Thomas J. Dolan and John F. Murphy. Dr. Gordon J. McCurdy presented a case of multiple abscesses of the brain which was discussed by Dr. Sargent. Dr. John G. Walsh gave a short talk on tuberculosis in pregnancy.

AMERICAN PUBLIC HEALTH ASSOCIATION

The 69th Annual Meeting of the American Public Health Association will be held in Detroit, Michigan, October 8-11, with the Book-Cadillac Hotel as headquarters.

The Annual Meeting of the American Public Health Association is the largest and most important health convention held on this continent. It will bring 3500 health officials to Detroit for a series of scientific meetings covering all phases of health protection and promotion. A Health Exhibit will be held in connection with the meeting and an Institute on Health Education is scheduled prior to the official opening.

Dr. Reginald M. Atwater is Executive Secretary of the American Public Health Association, with offices at 50 West 50th Street, New York City.

AMERICAN MEDICAL GOLFING ASSOCIATION

The American Medical Golfing Association's Twenty-Sixth Annual Tournament will be held at Winged Foot Golf Club, Mamaroneck, New York, Monday, June 10, 1940. Winged Foot has two famous championship courses and a beautiful clubhouse.

Some 250, out of the 1,360 Fellows of the A. M. G. A., are expected to take part at Winged Foot in the 36-hole competition. Each contestant will play both courses. The hours for teeing off are from 7:00 A. M. to 2:00 P. M.

The sixty prizes, in the nine Events, will be distributed after the banquet at the clubhouse at 7:00 P. M.

Officers of the A. M. G. A. for 1940 are George Washington Hall, M.D., Chicago, President; D. H. Houston, M.D., Seattle, First Vice-President; Grayson Carroll, M.D., St. Louis, Second Vice-President; Bill Burns, Secretary, 2020 Olds Tower, Lansing, Michigan.

The New York Golf Committee is composed of James Craig Joyner, M.D., Chairman, 718 Park Avenue, New York; Edwin G. Zabriskie, M.D., Charlton Wallace, M.D., Orrin Page Wightman, M.D., and Asa Liggett Lincoln, M.D.

All members of the A. M. A. are eligible for Fellowship in the A. M. G. A. For registration application write the Secretary.

RECENT BOOKS

THE PATIENT'S DILEMMA, The Quest for Medical Security in America. By Hugh Cabot, M.D., pp. 284, Cloth, \$2.50, Reynal & Hitchcock, New York, 1940.

This book deals with that vexed question of the needs and shortcomings of medical care as it is provided at present for the people of the United States. The data contained are presented so as to be readily understood by the general public. Dr. Cabot outlines the essentials of good medical care, discusses at length the cost involved both from the patient's and doctor's point of view, and finally contracts various methods of supplying medical care now in operation in this country. He disagrees heartily with the official policy of the American Medical Association, and takes no pains to conceal the fact. His own preference seems to be for some form of group medical practice. In such a system as he outlines it the physicians, many of them fresh from internships and residencies, would all be paid on a salary basis, opportunities for thorough laboratory and X-ray study would be provided, specialists would be available for frequent consultation, and the cost to the patient would be reduced through elimination of overhead and through bulk purchases of supplies. It is interesting to note in this connection that he himself has been a member of the Mayo Clinic for the past several years.

Although it adds little either in substance or interpretation to this much discussed subject the author's genuine sincerity and his wide experience make the book worthy of thoughtful consideration.

MORGAN CUTTS, M.D.

MANUAL OF DISEASES OF THE EYE FOR STUDENTS AND GENERAL PRACTITIONERS. By Charles H. May, M.D. with the assistance of Charles A. Perera, M.D. Sixteenth edition, pp. 515, with 387 text illustrations and 31 color plates. Cloth, \$4.00 William Wood & Company, Baltimore, 1939.

Dr. May's well-known book continues to fulfill well its purpose as a text for medical students and practitioners in general.

In this new edition the author, aided by Dr. Chas. A. Perera, has effectively brought the subject matter up to date. This revision is evident in all chapters.

An increase in the number of colored plates adds to the instructive value of the volume.

FRANK W. DIMMITT, M.D.